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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

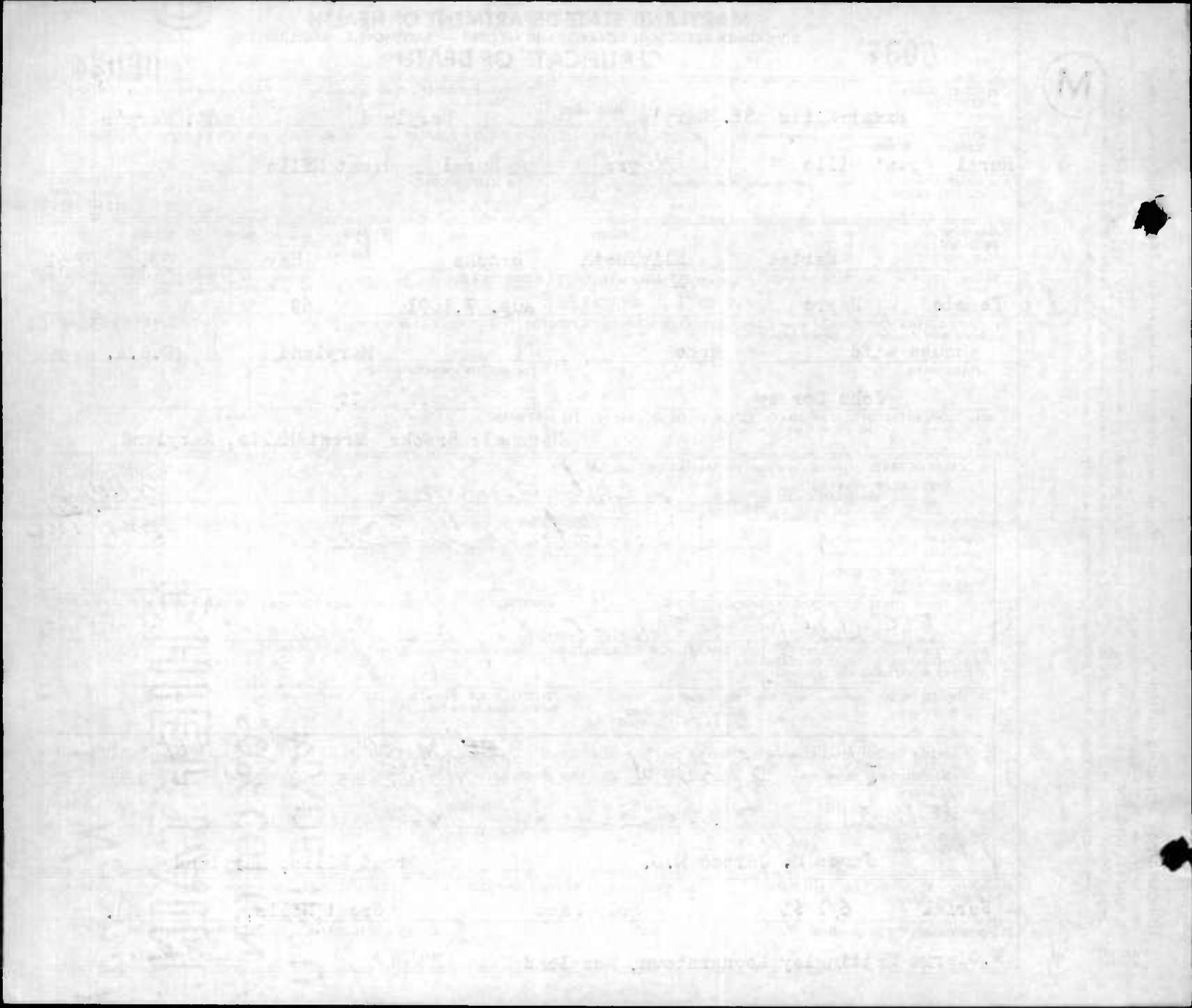
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6037

06024

1. PLACE OF DEATH a. COUNTY Exantz Mills St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Great Mills		c. LENGTH OF STAY IN 1b 30 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 		d. STREET ADDRESS X Rural Great Mills	
3. NAME OF DECEASED (Type or print) Martha Elizabeth Brooks		First Middle Last	4. DATE OF DEATH Month Month Day Year May 30, 1961
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 7, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Dorsey		14. MOTHER'S MAIDEN NAME ?? ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	17. INFORMANT Marshall Brooks Great Mills, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 715X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Septicemia Decubitus Ulcers INTERVAL BETWEEN ONSET AND DEATH 2 days months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) FSCND Fracture of hip 2 yrs ago.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred on _____, from the causes and on the date stated above.		20f. (City or town) July 18, 1960, to July 30, 1961	
22a. SIGNATURE James P. Jarboe		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) James P. Jarboe M.D.		22d. ADDRESS Great Mills, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/1/61	23c. NAME OF CEMETERY OR CREMATORIAL Holy Face	23d. LOCATION (City, town, or county) (State) Great Mills, Md.
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS	25a. REC'D BY REGISTRAR JUN 5 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		6038		Item 1 Film 6287 5/12/61 m		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)		
St. Mary's MARYLAND				a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		3 yrs		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Scotland		Private residence: Mrs. Dorothy Ridgell		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		X Rural Mechanicsville d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
John C.				Buckler	May	9	19	61
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 1, 1881	79 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
				Maryland		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
George W. Buckler		Victoria McGinley						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
(If yes give war or dates of service)				Mrs Elizabeth Burch Charlotte Hall, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary Edema						
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		Congestive Heart Failure					days	
} (c) DUE TO		A S C V D,					years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 5/19	(County) 1961	(State) 5/19	
21. I certify that (I) (this hospital) attended the deceased from.....		5/19		1961 to..... 5/19, 1961, that (I) (we) last saw the deceased alive on..... 5/19, 1961, and that death occurred at 5/19, 1961, from the causes and on the date stated above.				
22a. SIGNATURE James P. Jarboe		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES P. JARBOE, M.D.		22d. ADDRESS Great Mills, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/61	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion	23d. LOCATION (City, town or county) Laurel Grove, Maryland (State)				
24 FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.		25a. REC'D BY REGISTRAR D MAY 15 '61		25b. REGISTRAR'S SIGNATURE Charles S. Thorne		

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VR A15 (4)
15M 9/60

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Information Letter

Information

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Information

Information

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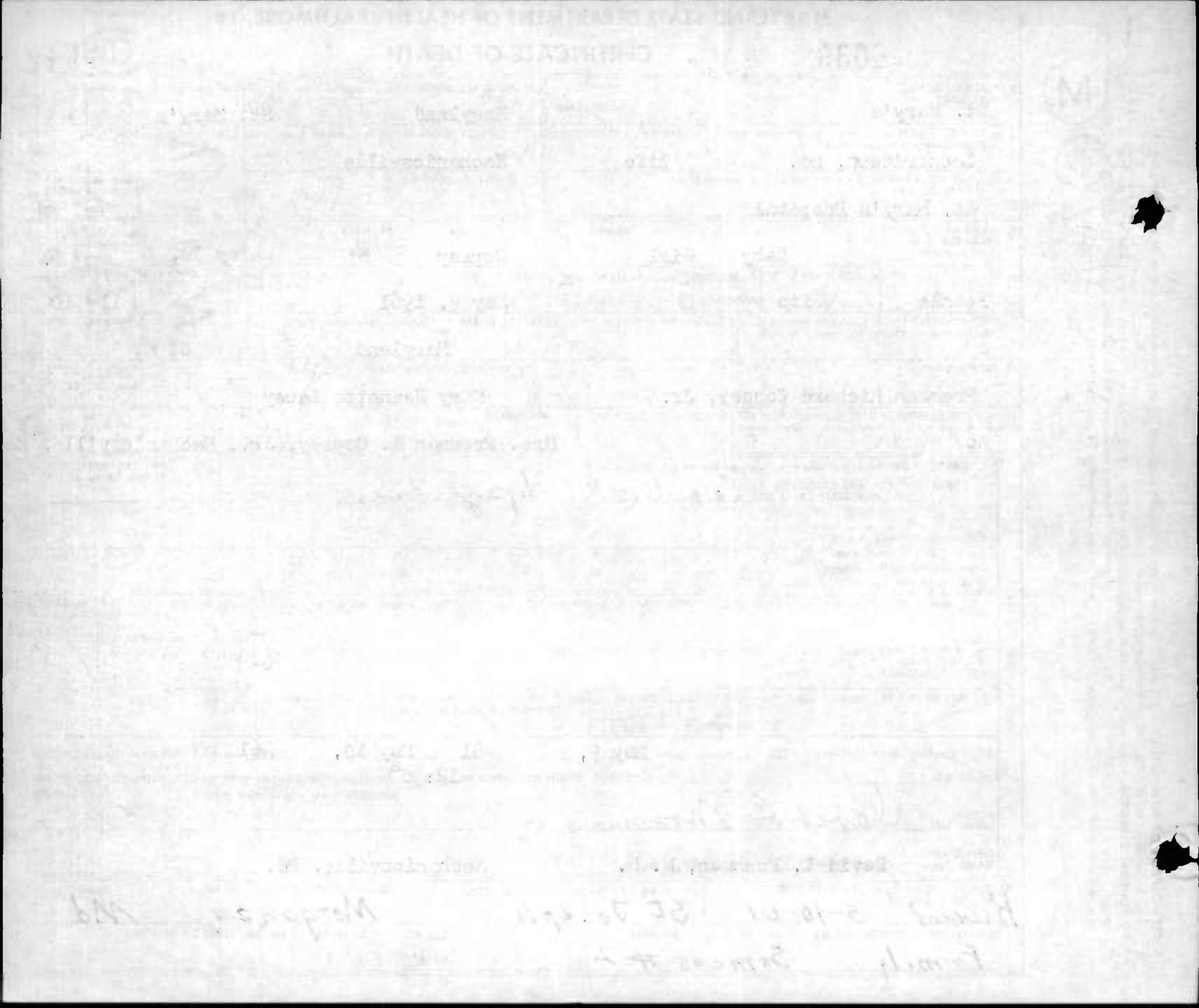
Information

Information

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
Reg. Dist. No. <u>6039</u> <u>6026</u>											
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown, Md.</u>				c. LENGTH OF STAY IN 1b <u>life</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mechanicsville</u>							
3. NAME OF DECEASED (Type or print) <u>Baby Girl</u>				4. DATE OF DEATH <u>Copsey</u> Month <u>May</u> Day <u>10</u> Year <u>1961</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 9, 1961</u>		9. AGE (In years lost birthday) yrs. <u>-</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>10</u> Hours <u>11</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>											
13. FATHER'S NAME <u>Freeman Richard Copsey, Jr.</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jeanette Lacey</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		INFORMANT		Address <u>Mrs. Freeman R. Copsey, Jr., Mechanicsville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Degeneration</u> INTERVAL BETWEEN ONSET AND DEATH <u>753.1</u>											
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>(b)</u> <u>(c)</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? <u>NO</u> YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>May 9</u> <u>19</u> p. m.		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>20f. (City or town)</u> <u>(County)</u> <u>(State)</u>							
21. I certify that I attended the deceased from <u>May 9, 1961</u> , to <u>May 10, 1961</u> , that I last saw the deceased alive on <u>May 9, 1961</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mechanicsville, Md.</u> DATE SIGNED <u>5/11/61</u>											
ACTUAL SIGNATURE <u>David L. Mossman</u> M.D.											
PHYSICIAN'S NAME (Type) <u>David L. Mossman, M. D.</u> Mechanicsville, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-10-61</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>ST Joseph</u>				22d. LOCATION (City, town, or county) <u>Morganza</u> (State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Family</u>		ADDRESS <u>Same as #2</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Traus</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Traus</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 06027		
6040 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY St. Mary's					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown			c. LENGTH OF STAY IN lb 10 hr.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clements			d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital										e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Baby	Middle Boy	Last Dean	4. DATE OF DEATH		Month May	Day 11	Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1961		9. AGE (In years last birthday) — yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Francis Ethelbert Dean					14. MOTHER'S MAIDEN NAME Carole Marie Gardner							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none			INFORMANT Mrs. Francis E. Dean, Clements, Md.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH 12 hr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that I attended the deceased from May 10, 1961 , to May 11, 1961 , that I last saw the deceased alive on May 10, 1961 , and that death occurred at 4 A.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE William D. Boyd										DATE SIGNED		
PHYSICIAN'S NAME (Type) William D. Boyd, M. D.										Leonardtown, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-11-61		22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart			22d. LOCATION (City, town, or county) Bushwood			(State) Md		
23. FUNERAL DIRECTOR'S SIGNATURE Family Same as #2					ADDRESS		24a. REC'D BY REGISTRAR Arthur S. Kraus		24b. REGISTRAR'S SIGNATURE			
							DATE May 23 '61					

Entomologist

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6041

CERTIFICATE OF DEATH

06028

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown	c. LENGTH OF STAY IN 1b 28 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakley	d. STREET ADDRESS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ellen	Middle Catherine	Last Hall
4. DATE OF DEATH	Month May	Day 31,	Year 1961
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 10, 1888
8. AGE (In years last birthday) yrs. 72	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jim Hall	14. MOTHER'S MAIDEN NAME Ann ??		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Frank B. Hall	Address Oakley, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH DUE TO Renal Failure 10 year Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Renal Failure 30 day. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1958 to May 31, 1961 , that (I) (we) last saw the deceased alive on May 31, 1961 , and that death occurred at 130A , from the causes and on the date stated above.	22a. SIGNATURE William D. Boyd M. D.		
22c. PHYSICIAN'S NAME (Type) William D. Boyd M. D.	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 5/31/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/2/61	23c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart	23d. LOCATION (City, town, or county) (State) Bushwood, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE JUN 5 '61	25b. REGISTRAR'S SIGNATURE Charles S. Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

6042

06029

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MAMIE		First	Middle	Last	4. DATE OF DEATH JOHNSON	Month	Day	Year
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH JULY 16, 1879	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME THOMAS G. HARDING				14. MOTHER'S MAIDEN NAME SUSAN GRAVES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT GLADYS J. McNEY - LEONARDTOWN, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33/X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<i>Cerebrovascular accident</i>		5 days.		
DUE TO (c)				<i>Generalized arteriosclerosis</i>		5 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that (I) (this hospital) attended the deceased from May 19, 1956 to 26 May, 1961 , that (I) (we) last saw the deceased alive on 26 May, 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.								
22a. SIGNATURE <i>Joseph E. Gill</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 5/27/61		
22c. PHYSICIAN'S NAME (Type) JOS. E. GILL, MD		22d. ADDRESS LEONARDTOWN, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/29/61		23c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius Cem.		23d. LOCATION (City, town, or county) Leonardtown, Md.		(State)
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 31 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

6043

CERTIFICATE OF DEATH

06030

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 902-B MOQ, USNAS, Patuxent River,	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION Station Hospital, USNAS, Patuxent		d. STREET ADDRESS Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Helen	Middle Roberta	Last JOHNSTON
4. DATE OF DEATH	Month May	Day 15	Year 61
S. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1923
9. AGE (In years (last birthday) yrs.) 37	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Iowa	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robert BERSTROM	14. MOTHER'S MAIDEN NAME Helen SHUMWAY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Lloyd Edward JOHNSTON, MOQ 902-B, USNAS, Patuxent River, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUPUS ERYTHEMATOUS DISSEMINATUS DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 24 April 1961 to 15 May 1961, that (I) (we) last saw the deceased alive on 15 May 1961, and that death occurred at 715 PM, from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) D. E. MULHATTEN, LT MC USN		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Station Hospital, U.S. Naval Air Station, Patuxent River, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/17/61	23c. NAME OF CEMETERY OR CREMATORIAL Christ Church	23d. LOCATION (City, town, or county) Chaptico, (State) Maryland
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland	ADDRESS	25a. REC'D BY REGISTRAR DATE MAY 17 '61	25b. REGISTRAR'S SIGNATURE Anthony S. Thomas

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6044 06031

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clements			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Andrew	Middle Clarence	Last Latham Jr.	4. DATE OF DEATH Month May	Day 19	Year 1961
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH April 13, 1904	9. AGE (In years last birthday) yrs. 57	IF UNDER 1 YEAR Months 57	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Clarence Latham Sr.		14. MOTHER'S MAIDEN NAME Jane Celeste Mattingly		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219 12 4060		17. INFORMANT Mrs Celesta Bowles Clements, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Acute coronary occlusion Coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH 10-15 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) DUE TO (c)				10415.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred at _____ from the causes and on the date stated above.				July 1955 to May 1961			
22a. SIGNATURE Leonard Bembe M.D.		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) for David L. Mossman M. D.		22d. ADDRESS Mechanicsville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/22/61		23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's		23d. LOCATION (City, town, or county) (State) Morganza, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 23 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06052

6045		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY St. Mary's		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Piney Point		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Blanch		4. DATE OF DEATH Month Day Year May 15, 1961	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Morgan		14. MOTHER'S MAIDEN NAME Patsy Seldon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Daniel Morgan Piney Point, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Causes of right breast</i> DUE TO 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Heart disease</i> INTERVAL BETWEEN ONSET AND DEATH <i>over 5 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>May 23, 1940</i> to <i>May 15, 1961</i> , that (I) (we) last saw the deceased alive on <i>March 24, 1961</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Robert T. Fuchs</i>		22b. DATE SIGNED <i>5/16/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert T. Fuchs</i>		22d. ADDRESS <i>Leonardtown, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/18/61	
23c. NAME OF CEMETERY OR CREMATORIAL St. Mark's		23d. LOCATION (City, town, or county) (State) Valley Lee, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS	
		25a. REC'D BY REGISTRAR MAY 17 '61	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Tracy</i>	

810

STATION STATEMENT

GRANTANOPOLIS CALIFORNIA

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11100 ZULU 11200 ZULU

11100 ZULU

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

6046

CERTIFICATE OF DEATH

06033

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown		b. COUNTY St. Mary's	
c. LENGTH OF STAY IN lb 6 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Leonardtown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Mary's Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Francis		First	Middle
4. DATE OF DEATH Sterling		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH Oct. 22, 1911		9. AGE (In years last birthday) 49 yrs.	10. IF UNDER 1 YEAR Months 0 Dey 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Md. State Roads		10b. KIND OF BUSINESS OR INDUSTRY Md. State Roads	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		Address	
13. FATHER'S NAME Lynwood J. Sterling		14. MOTHER'S MAIDEN NAME Ruth E. Camalier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give rank or date of service)		16. SOCIAL SECURITY NO. 213-30-7682	
17. INFORMANT Mrs Ruth E. Sterling		18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatitis + Nephritis	
583X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19:		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Leonardtown, Maryland
20f. (City or town) Leonardtown		(County) Maryland	
(State) Maryland			
21. I certify that (I) (This hospital) attended the deceased from May 7 to May 14, 1961 , that (I) (we) last saw the deceased alive on May 7, 1961 , and that death occurred at Leonardtown from the causes and on the date stated above.		22b. DATE SIGNED 5/15/61	
22e. SIGNATURE Charles Greenwell		ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) Charles Greenwell M.D.		STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS Leonardtown, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17, 1961	23c. NAME OF CEMETERY OR CREMATORIAL St. Aloysius
23d. LOCATION (City, town or county) Leonardtown, Maryland		(State) Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS	25a. REC'D BY REGISTRAR DATE MAY 16 '61
			25b. REGISTRAR'S SIGNATURE Arthur S. Haas

EXHIBIT

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